

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

9 7 — 0 2 5

2. STATE:

LOUISIANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

November 3, 1997

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)-

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.253; OBRA-90; P.L. 101.508 Sections
4702 & 4703

7. FEDERAL BUDGET IMPACT:

a. FFY 1997-98 \$ 13,760.140
b. FFY 1998-99 \$ ~~14,172.944~~ 14,241,754

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Item 1, Pages 10d-10i

See attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):Attachment 4.19-A, Item 1, Pages 10d-10k
(TN 97-04)

See attachment

10. SUBJECT OF AMENDMENT: The purpose of this amendment is to establish regulations to govern
disproportionate share hospital payment methodologies for those facilities that meet the
definition and criteria for small rural hospitals.

11. GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: The Governor does
not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Bobby P. Jindal

14. TITLE:

Secretary

15. DATE SUBMITTED:

December 29, 1997

16. RETURN TO:

State of Louisiana
Department of Health and Hospitals
1201 Capitol Access Road
P.O. Box 91030
Baton Rouge, LA 70821-9030**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

DECEMBER 31, 1997

18. DATE APPROVED:

JUNE 6, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

NOVEMBER 3, 1997

20. SIGNATURE OF REGIONAL OFFICIAL:

Sandra Hall

21. TYPED NAME:

for CALVIN G. CLINE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID STATE OPERATIONS

23. REMARKS:

* Per State's letter dated 3/11/98

Calvin Cline
April 12, 2001
Page 4

Previously pending plan amendments TN 94-11, TN 94-33, and TN 95-29 were approved subsequent to the stop-the-clock letter for this transmittal, and TN 95-30, and TN 97-04 have been submitted for approval. The language changes from those transmittals have been incorporated in the current transmittal.

In addition to the issues cited in the stop-the-clock letter, we have included the definition of small rural hospitals previously submitted from the substitute pages forwarded with the responses to informal questions regarding TN 97-25 dated March 11, 1998.

The attached pages are to be substituted according to the following chart, and blocks 8 and 9 of HCFA 179 amended to read as follows. We have included a column that describes the changes to that page for your convenience.

Pg 10d same 97-04

Block 8	Block 9	Changes
10e	same (TN 97-04)	amend references to locations of reduction methodology at top of the page, adds different qualification period for small rural hospitals
10f	same (TN 97-04)	removes common definitions of rural and small hospitals
10g	same (TN 97-04)	continues repagination
10j	same (TN 97-04)	removes small public local government hospitals and small private rural hospitals, replaces with small rural hospitals in 2 pools
10j(1)	same (TN 97-04)	in item 3.b.3), changes to "small rural hospitals"
10k	same (TN 97-04)	adds rehabilitation hospitals and long-term care hospitals to "other" group, and adds definition for these hospitals

Please consider this a formal request to begin the 90-day clock. It is anticipated that the above clarifications and additional information will be sufficient to result in approval of the pending State plan amendment. If further information is needed, please contact Virginia Lee at (504)342-1400.

STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE

OR

(iii) Effective November 3, 1997 hospitals meeting the definition of small rural hospital as defined in 3.b. below.

AND

- e. In addition to the qualification criteria outlined in Item I.D.1.a.-d. above, effective July 1, 1994, the qualifying disproportionate share hospital must also have a Medicaid inpatient utilization rate of at least one percent (1%).

2. General Provisions for Disproportionate Share Payments

- a. Disproportionate share payments cumulative for all DSH payments under all DSH payment methodologies shall not exceed the federal disproportionate share state allotment for each federal fiscal year or the state appropriation for disproportionate share payments for each state fiscal year. The Department shall make necessary downward adjustments to hospitals' disproportionate share payments to remain within the federal disproportionate share allotment or the state disproportionate share appropriated amount.

The state will allocate the reduction between state and non-state hospitals based on the pro rata share of the amount appropriated for state hospitals and non-state hospitals multiplied by the amount of disproportionate share payments that exceed the federal disproportionate share allotment.

The reduction will be allocated between the non-state hospital groups based on the pro rata share of each group's payments divided by the sum of payments for all groups.

Methodologies for hospitals within groups are found as follows:

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DATE EFF <u>11-3-97</u>
HCFA 179 <u>TN 97-85</u>
<u>A</u>

97-04

TN# _____
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TN# _____

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PLAN

ATTACHMENT 4.19-A
Item 1, Page 10e

STATE OF LOUISIANA

ORIGINAL STATE COPY

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE

Item I.D.3.a(3) for public state-operated hospitals

Item I.D.3.b(4) for small rural hospitals

Item I.D.3.c.(6) for all other hospitals

- b. Appropriate action shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.
- c. DSH payments to a hospital determined under any of the methodologies below shall not exceed the hospital's net uncompensated cost as defined in Item I.D.2.f. for the state fiscal year to which the payment is applicable.
- d. Qualification is based on the hospital's latest year end cost report for the year ended during the period July 1 through June 30 of the previous state fiscal year, except that a small rural hospital's qualification is based on the hospital's year end cost report for the year ending during the period April 1 through March 31 of the previous year.

Example: A hospital has a fiscal year ending September 30, 1995. The disproportionate share payment made after October 1, 1995, would be based on the September 30, 1994 cost report. Effective October 1, 1996, payment would be made on the hospital's September 30, 1995 cost report.

Hospitals are notified by letter at least 60 days in advance of calculation of the DSH payment to submit documentation required to establish DSH qualification. Required documents are: 1) obstetrical qualification criteria form; 2) low income utilization revenue calculation (if applicable); 3) Medicaid cost report; and 4) uncompensated cost calculation. Only hospitals which have submitted the qualification documentation by the deadline stated in the notification letter will be considered for disproportionate share payments. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization.

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PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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- e. Hospitals/units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle and thereafter.
- f. Net Uncompensated Cost - cost of furnishing inpatient and outpatient hospital services net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payor payments, and all other inpatient and outpatient payments received from patients. For example: The hospital's actual cost for delivering a baby for a specific patient stay is \$3,000. The patient's insurance covers the service, but only pays \$1,000. For this particular patient, the entire \$3,000 must be included in the costs associated with patients who have insurance for services provided. It is mandatory that qualifying hospitals seek all third party payments including Medicare, Medicaid, and other third party carriers.
- g. Definitions applicable to all hospital groups
- 1) Urban hospital -a hospital located in a Metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification under Medicare.
 - 2) Distinct Part Psychiatric Units - distinct part psychiatric psychiatric units of acute care, long term care, or rehabilitations general hospitals which meet Medicare criteria for PPS exempt units and are enrolled under a separate Medicaid provider number.
 - 3) Freestanding Psychiatric Hospital - a psychiatric hospital which is not part of another hospital and is enrolled as a Medicaid psychiatric hospital.

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MEDICAL ASSISTANCE PLAN

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Item 1, Page 10g

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PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE

- h. Recoupment of overpayment shall be redistributed to the hospital with the largest number of inpatient days attributable to individuals entitled to benefits under the State Plan of any hospitals in the State for the federal fiscal year in which the recoupment is applicable until the total DSH amount paid that hospital equals 100% of the hospital's net uncompensated cost.

To determine the hospital that has the largest number of Medicaid inpatient days, the fiscal year end cost report that established the DSH payment for the year in which the recoupment is applicable will be used. The redistribution shall occur after audit and/or desk review of reported days. For purposes of the DSH allotment the redistributed amount shall apply to the original payment year in which the recoupment pertains.

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b. Small Rural Hospitals

- 1) A Small Rural Hospital is defined as a hospital (other than a long-term care hospital, rehabilitation hospital, or free-standing psychiatric hospital but including distinct part psychiatric units) meeting the following criteria:

A qualifying hospital a) has no more than sixty beds as of July 1, 1994; and: 1) is located in a parish with a population of less than fifty thousand; or 2) is located in a municipality with a population of less than twenty thousand.

OR

- b) meets the qualifications of a sole community hospital under 42 CFR §412.92(a).
- 2) Payment is based on uncompensated cost for qualifying small rural hospitals in the following two pools:
- a) Public (non-state) Small Rural Hospitals are small rural hospitals as defined above which are owned by a local government;
- b) Private Small Rural Hospitals are small rural hospitals as defined above that are privately owned.

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ATTACHMENT 4 19-A
Item 1, Page 10(c1)

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- 3) DSH payments to small rural hospitals are prospective, and paid once per year for the federal fiscal year. Payment is equal to each qualifying hospital's pro rata share of uncompensated cost as defined in I.D.2.f for the hospital's fiscal year end cost report ending during April 1 through March 31 of the previous year for all hospitals meeting these criteria multiplied by the state appropriation for disproportionate share payments allocated for this pool of hospitals.
- 4) A pro rata decrease necessitated by conditions specified in I.D.2.a. above for hospitals described in this section will be calculated based on the ratio determined by dividing the hospitals' uncompensated costs by the uncompensated costs for all qualifying hospitals in this section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment or the state DSH apportioned amount.

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c. **All Other Hospitals (Private Rural Hospitals Over 60 Beds, All Private Urban Hospitals, Public Non-State Hospitals Over 60 Beds, All Free-Standing Psychiatric Hospitals exclusive of State Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals)**

1) Criteria for hospitals to be included in this group are as follows:

- a) Private rural hospitals over 60 beds - privately owned acute care general, rehabilitation, and long term care hospitals including distinct part psychiatric units having more than 60 beds that are not located in a Metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification for Medicare.
- b) All private urban hospitals - privately owned acute care general, rehabilitation, and long term care hospitals including distinct part psychiatric units that are located in a metropolitan Statistical Area as defined per the 1990 census. This excludes any reclassification under Medicare.
- c) Public non-state hospitals over 60 beds - local government-owned acute care general, rehabilitation, and long-term care hospitals including distinct part psychiatric units having more than 60 beds.
- d) All free-standing psychiatric hospitals exclusive of state hospitals - privately owned and local government owned psychiatric hospitals of any size.
- e) Rehabilitation hospitals and long-term care hospitals - hospitals which meet Medicare specialty designation

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